OPTIMA HEALTH PLAN

MEDICAL PRIOR AUTHORIZATION REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Xenleta™ (lefamulin) **for IV Infusion (Medical) (J0691/C9054)**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: ____

Dosing Schedule: ______________________________ **Length of Therapy**: ____________________

Diagnosis: ___________________________________ **ICD Code, if applicable:** ________________

Members Current Weight: ____________________

INFORMATIONAL NOTE: IV Formulation for treatement in an inpatient setting (chart notes, medication orders/history need to accompany this request). Switching to oral formulation will require prior authorization.

- ❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ The patient has a diagnosis for Community Acquired Bacterial Pneumonia (CABP)
- ❑ **If classified as Severe CABP**, sputum and/or blood cultures are attached observing susceptible pathogens
- ❑ ALL of the following have been tried:
  - ❑ Beta-lactam antibiotic (ampicillin/sulfabactam, cefotaxime, ceftriaxone) PLUS a macrolide antibiotic (azithromycin, clarithromycin)
  - ❑ Monotherapy with a respiratory fluoroquinolone
  - ❑ Beta-lactam antibiotic **PLUS** doxycycline
- ❑ **Document any intolerabilities/contraindications/resistance to the above therapies (include medical documentation):**

____

____

____

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Medication being provided by (check box below that applies):

- ❑ **Location/site of drug administration: ____**

  NPI or DEA # of administering location: ____

OR

- ❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Optima Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Optima's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Member Name: ____

Member Optima #: _______________________________________ Date of Birth: ______________________

Prescriber Name: ____

Prescriber Signature: ____ Date: __________________

Office Contact Name: ____

Phone Number: ______________________________________ Fax Number: __________________________

DEA OR NPI #: ____

***Approved by Pharmacy and Therapeutics Committee**: 2/20/2020
REVISED/UPDATED: ~~3/10/2020;~~ **7/1/2020**